SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Filing at a Glance

Company: Lincoln Benefit Life Company

Product Name: LA2008 series	SERFF Tr Num: ALSB-125531450	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 39394
Sub-TOI: L08.000 Life - Other	Co Tr Num: LA2008 SERIES	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Karen Roberts	Disposition Date: 06/25/2008
	Date Submitted: 06/24/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: LA2008 series	Status of Filing in Domicile: Authorized
Project Number: LA2008 series	Date Approved in Domicile: 06/19/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/25/2008	
State Status Changed: 06/25/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: LA2008 – Application for Life Insurance

LA2008TIA – Temporary Insurance Report

LA2008PF – Premium Finance Supplement to Life Application

We submit the above-referenced forms for your attention and approval. These are new forms, not previously submitted, and they do not replace any currently approved forms.

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Description of Forms

Application form LA2008 is a new business application that will be used to write all life insurance policies previously approved by your Department. Form LA2008 may also be used to write life policies developed in the future.

Form LA2008TIA is a receipt and temporary insurance agreement.

Form LA2008PF is a premium finance supplement to life application. This form will be completed by proposed insureds whose premiums are to be funded directly or indirectly by a loan or advance from any person or entity other than the individual's employer.

These forms have been generated by our home office computer system. These forms may also be generated using other hardware, which can result in changes in formatting (e.g., typeface, margins, page breaks), but the contents will remain unaffected.

Please note that some of the variable information on the pdfs of these forms was bracketed using Adobe Acrobat. Although the bracketing appears on the attached pdfs when viewed electronically, the bracketing may not appear on printed hard copies unless your printer is given special instructions to do so.

We have also attached any other supplemental information as required by your state.

If you have any questions, please feel free to contact me at the address, phone, or e-mail provided. Thank you for your consideration of this matter.

Sincerely,

Karen M. Roberts
Senior Product & Financial Analyst
Contract Development and Filing

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Company and Contact

Filing Contact Information

Karen Roberts,
3100 Sanders Rd, Suite M2A
Northbrook, IL 60062

krobq@allstate.com
(847) 402-8531 [Phone]

Filing Company Information

Lincoln Benefit Life Company
2940 South 84th Street
Lincoln, NE 68506-4142
(800) 525-2799 ext. [Phone]

CoCode: 65595
Group Code: 8
Group Name:
FEIN Number: 47-0221457

State of Domicile: Nebraska
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	$20 per application form $20 x 3 forms = $60
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Benefit Life Company	$60.00	06/24/2008	21062378

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/25/2008	06/25/2008

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Disposition

Disposition Date: 06/25/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Readability Certification		Yes
Supporting Document	Statement of Variability		Yes
Form	Application for Life Insurance		Yes
Form	Temporary Insurance Agreement		Yes
Form	Premium Finance Supplement		Yes

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Form Schedule

Lead Form Number: LA2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LA2008	Application/ Enrollment Form	Application for Life Insurance	Initial		47	LA2008_Life Insurance Application.pdf
	LA2008TIA	Application/ Enrollment Form	Temporary Insurance Agreement	Initial		51	LA2008TIA Temporary Insurance Agreement.pdf
	LA2008PF	Application/ Enrollment Form	Premium Finance Supplement	Initial		55	LA2008PF Premium Finance Supplement.pdf

APPLICATION FOR LIFE INSURANCE

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

Lincoln Benefit Life Company
P. O. Box 80469, Lincoln, NE 68501-0469
Tel: 800-525-9287

PART 1

Section A - Primary Proposed Insured

1. Name (First, Middle, Last)			2. Birth Date (MM/DD/YYYY)	3. Birth State/Country
Home Address			4. How long at this address?	5. Sex ❑ M ❑ F
City	State	ZIP	6. Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced	
7. Home Phone Number ( )	8. Work Phone Number ( )	9. Driver's License Number / State	10. SSN/TIN	
11. Employer Name	12. Occupation and Duties		13. Annual Income $	14. Height and Weight Ft. In. Lbs.

15. Has the Primary Insured ever used cigarettes, cigars, a pipe, chewing tobacco, nicotine gum, or any other product containing tobacco or nicotine?

- ❑ No, has never used any tobacco or nicotine product
- ❑ Yes, has used tobacco or nicotine product, but not in the past 5 years
- ❑ Yes, has used tobacco or a nicotine product in the past 5 years, but does not currently (please complete question 17)
- ❑ Yes, currently uses tobacco or a nicotine product (please complete question 16)

16. Tobacco or nicotine products **currently used:**

- ❑ Cigarettes-Packs/Day_____
- ❑ Other _____
  Frequency _____

17. If the Primary Insured used any tobacco or nicotine products **in the past 5 years:**

- ❑ Type_____
- ❑ When quit?_____ (MM/YYYY)

18. Primary Beneficiary (First, Middle, Last)	Relationship to Primary Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

Primary Beneficiary's Address: ❑ Same as Primary Insured's ❑ Other Address:

19. Contingent Beneficiary (First, Middle, Last)	Relationship to Primary Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

This page must be submitted even if blank.

Section B — Proposed Additional or Joint Insured *(If more than one, submit additional copies of Section B.)*

1. Name (First, Middle, Last)			2. Birth Date (MM/DD/YYYY)	3. Birth State/Country
Home Address			4. How long at this address?	5. Sex ❑ M ❑ F
City	State	ZIP	6. Relationship to Primary Insured	

7. Home Phone Number ( )	8. Work Phone Number ( )	9. Driver's License Number / State	10. SSN/TIN

11. Employer Name	12. Occupation and Duties	13. Annual Income $	14. Height and Weight Ft. In. Lbs.

15. Has the Additional/Joint Insured ever used cigarettes, cigars, a pipe, chewing tobacco, nicotine gum, or any other product containing tobacco or nicotine?
- ❑ No, has never used any tobacco or nicotine product
- ❑ Yes, has used tobacco or nicotine product, but not in the past 5 years
- ❑ Yes, has used tobacco or a nicotine product in the past 5 years, but does not currently (please complete question 17)
- ❑ Yes, currently uses tobacco or a nicotine product (please complete question 16)

16. Tobacco or nicotine products **currently used:**
- ❑ Cigarettes-Packs/Day _____
- ❑ Other _____
- Frequency _____

17. If the Additional/Joint Insured used any tobacco or nicotine products **in the past 5 years:**
- ❑ Type _____
- ❑ When quit? _____ (MM/YYYY)

18. Primary Beneficiary (First, Middle, Last) (Only applicable to Additional Insured Rider)	Relationship to Additional Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

Primary Beneficiary's Address: ❑ Same as Additional Insured's ❑ Other Address:

19. Contingent Beneficiary (First, Middle, Last) (Only applicable to Additional Insured Rider)	Relationship to Additional Insured	Birth Date/Date of Trust (MM/DD/YYYY)	SSN/TIN	% Share (if not equal)

❑ Contingent Beneficiary(ies) for Additional Insured same as those for Primary Proposed Insured shown in Section A, no. 19.

Section C - Children Proposed for Children's Level Term Rider (CLTR) *[Must be Primary Insured's (a) children, stepchildren living with Primary Insured, or legally adopted children, and (b) age 17 or less. Not available if owner is a business.]*

1. Name (First, Middle, Last)	2. Birth Date (MM/DD/YYYY)	3. Age	4. Sex	5. SSN
			❑ M ❑ F	
			❑ M ❑ F	
			❑ M ❑ F	
			❑ M ❑ F	

Section D - Owner/Payor If Other Than Primary Proposed Insured

1. Name (First, Middle, Last) ❑ Owner ❑ Payor *(as permitted)*			2. Relationship to Primary Insured
Street Address		3. Home Phone Number ( )	4. Other Phone Number ( )
City	State ZIP	5. Birth Date (MM/DD/YYYY)	6. SSN/TIN

Section E - Citizenship

1. Are all Proposed Insureds, Beneficiaries, Owners, and Payors citizens of the United States? ❑ Yes ❑ No *(If "no," give details below)*

Name and Party (e.g., "Insured")	Country	❑ Perm. Res. Card No. _____ *Attach copy if* ❑ Visa No. and Type _____ *available.*
Name and Party (e.g., "Insured")	Country	❑ Perm. Res. Card No. _____ *Attach copy if* ❑ Visa No. and Type _____ *available.*

Section F - The Policy

1. Plan of Insurance *(for term plans, include level period)*	2. Base Face Amount $	3. Death Benefit Option (UL/VUL only) ❑ 1 ❑ 2 ❑ 3 (if available)	4. ❑ APL *(for Whole Life only)*

5. Additional Benefits, Riders, Options: ❑ WP ❑ COP $ _____ ❑ ROP ❑ CLTR _____ Units ($5,000 per unit)
❑ PTR $ _____ ❑ ADB (Primary Insured) $ _____ ❑ Date policy to save age (if within allowed timeframe)
❑ Other: _____

Additional Insured Rider(s):
❑ Name _____ $ _____ Level Period* _____ ❑ ADB on AIR $ _____
❑ Name _____ $ _____ Level Period* _____ ❑ ADB on AIR $ _____

** Required for AIR on term base policy only.*

6. UL/VUL Premium Information *(must match illustration)*	7. Premium Mode/Method *(must match illustration)*
Planned Modal Premium $ _____ Additional Lump Sum Premium $ _____ *(Includes expected 1035 funds if any.)*	❑ Single ❑ Semiannual ❑ Monthly EFT ❑ Annual ❑ Quarterly ❑ Other _____

Section G - Other Insurance and Replacement

1. Does anyone proposed for this insurance have any life insurance or annuity contracts (includes personal, business or group life):

	Yes	No
a. in force or application(s) pending in any company? *(If "yes," list below.)*	❑	❑
b. which have been or will be replaced, exchanged, changed or borrowed against because of this application? *(Circle applicable policy number below.)*	❑	❑
c. which will be part of a 1035 exchange because of this application? *(Must be from life insurance.)*	❑	❑

Give details below and submit any required replacement forms and policy illustrations.

Person Covered	Company	Face Amount	ADB Amount	Date Applied (MM/DD/YYYY)	Policy Number	Plan Type
		$	$			
		$	$			
		$	$			

Section H - Nonphysical Data and Preliminary Health Information

	Yes	No	Details of Yes Answers
1. With regard to driving record, has anyone proposed for insurance:			
a. had any moving violations in the past 3 years?	❑	❑	
b. other than above, been convicted of driving under the influence or reckless driving, or had their driver's license suspended or revoked, in the past 10 years?	❑	❑	
2. In the past 3 years, has anyone proposed for insurance:			
a. flown as a pilot or crew member of any aircraft? *(If "yes," attach questionnaire.)*	❑	❑	
b. engaged in sky or scuba diving, vehicle racing, mountain or rock climbing? *(If "yes," attach applicable questionnaire.)*	❑	❑	
3. Has anyone proposed for insurance EVER had an application for life insurance declined, postponed, rated, or modified?	❑	❑	
4. Are there any Proposed Insureds who have lived in the U.S. less than 3 years OR plan to travel outside the U.S. in the next 2 years? *(If "yes," attach questionnaire.)*	❑	❑	
Do not submit payment with application if any of questions 5(a-f) below are answered "yes" or not answered.			
5. In the past 10 years, has anyone proposed for insurance:			
a. been charged with a felony?	❑	❑	
b. used or been arrested for possession, sale or delivery of illegal drugs?	❑	❑	
c. sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind-altering substances not prescribed by a physician?	❑	❑	
d. been diagnosed or treated by a physician for heart attack, coronary artery disease or stroke, or been told they had any of these disorders?	❑	❑	
e. been treated for or diagnosed with cancer other than basal cell skin cancer?	❑	❑	
f. been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or been told they have AIDS?	❑	❑	

Section I - Premium Funding

	Yes	No	Details of Yes Answers
1. Will premiums for this policy be funded directly or indirectly by any loan or advance from any person or entity other than the Proposed Insured's employer? *(If "yes," complete the Premium Finance Supplement to Life Application.)*	❑	❑	
2. Has any Proposed Insured, Owner, or Beneficiary been given or offered cash, property, gifts, loan proceeds, or any other inducement to apply for or transfer any interest in this policy?	❑	❑	
3. Has any Proposed Insured or Owner agreed, or been advised or encouraged, to sell, assign, or transfer the policy, or any interest in the policy, to a settlement company, investor(s), charity, or other third party?	❑	❑	
4. With respect to this policy, will any trust, LLC, or other entity created by or on behalf of the Proposed Insured or Owner have the right to sell shares or certificates of interest, or any other interest in the policy to other parties?	❑	❑	
5. Are any existing life insurance policies on any Proposed Owner or Insured currently owned by, or in the process of being sold to, a viatical or settlement company, investor(s), or investment fund?	❑	❑	

Section J - Juvenile Insurance *(Complete if Primary or Additional Insured is under 18 years of age.)*

1. Please provide the amount of life insurance in force or applied for on the Primary/Additional Insured's:
   a. Mother (if mother is uninsurable or deceased, so indicate.) $ _____
   b. Father (if father is uninsurable or deceased, so indicate.) $ _____
2. Is the total insurance coverage in force and applied for equal for all siblings? ❑ Yes ❑ No
   (If "no," give details.) _____

CONTINUATION OF APPLICATION FOR LIFE INSURANCE - PART 2

1. Primary Insured's Physician's Name and Address *(If none, state "None.")*	Phone Number ( )

Date Last Seen	Reason Last Seen	Result (Diagnosis and Treatment)

2. Additional Insured's Physician's Name and Address *(If none, state "None.")*	Phone Number ( )

Date Last Seen	Reason Last Seen	Result (Diagnosis and Treatment)

3. Does any Primary or Additional Proposed Insured have a family history of heart disorder, stroke or cancer beginning before age 65 in any natural parent or sibling? *(If "yes," complete table below.)* ❑ Yes ❑ No

Proposed Insured	Which Relative?	Disorder	Age at Onset	Age at Death	Cause of Death	Age if Living

Questions 4 - 8 apply to all Proposed Insureds, including children proposed for coverage under CLTR.

	Yes	No
4. Has anyone proposed for insurance EVER been diagnosed with, or sought treatment or advice for:		
a. high blood pressure or any disorder of heart or blood vessels?	❑	❑
b. cancer or tumor?	❑	❑
c. dependency on or addiction to alcohol or any drug?	❑	❑
5. In the past 10 years, has anyone proposed for insurance been diagnosed with, or sought treatment or advice for:		
a. epilepsy or seizures, disorder of the brain or nervous system, mental or nervous disorder?	❑	❑
b. diabetes?	❑	❑
c. asthma, emphysema, sleep apnea, or any lung disorder?	❑	❑
d. any disorder of the digestive tract, liver or pancreas?	❑	❑
e. anemia or other disorder of blood or blood cells?	❑	❑
f. disorder of kidneys or reproductive organs?	❑	❑
g. arthritis or disorder of bones, skin or muscle?	❑	❑
6. Other than previously disclosed, in the past 5 years, has anyone proposed for insurance:		
a. had a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test?	❑	❑
b. been advised to have a medical consultation, diagnostic test, or surgery that HAS NOT been done?	❑	❑
7. Is anyone proposed for insurance taking any prescription or over-the-counter medications, herbs, supplements, or alternative medications not previously disclosed?	❑	❑
8. Has anyone proposed for insurance been told that any insurance company exams and/or lab specimens are required? *If "yes," give name(s) of Proposed Insured(s) here:* _____	❑	❑

Please Provide Details of "Yes" Answers to Questions 4 – 8 Below:

Question #	Proposed Insured	Date(s)	Medical Condition and How Treated	Current Status	Name and Address of Physician/Facility

Use this space if necessary for additional information.

Permit to Obtain and Disclose Certain Data

A. Lincoln Benefit Life Company, its reinsurers, consumer reporting agencies, and other parties acting on Lincoln Benefit Life Company's behalf may get data about my health, medical history, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, finances, credit history, driving record, and any criminal record. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for Lincoln Benefit Life Company to determine its obligations under the policy issued in connection with this application.

B. Any doctor, practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, the Medical Information Bureau, Inc. (MIB, Inc.), viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other person or entity which has such data about me may give such data to Lincoln Benefit Life Company and its reinsurers when this Permit or a copy of it is shown. All sources but the MIB, Inc., may give such data to agents or agencies acting on behalf of Lincoln Benefit Life Company. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by me or otherwise required by law. Covered entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether this Permit is signed.

C. Any request by Lincoln Benefit Life Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable statutes governing patient access to medical records.

D. Data about mental illness, alcoholism, sexually transmitted diseases, and the use of drugs is to be included.

E. Lincoln Benefit Life Company or its reinsurers may make a brief report about me to the MIB, Inc.

F. This Permit is good for 24 months after it is signed.

G. Lincoln Benefit Life Company may obtain an investigative consumer report ("inspection report") on me. ❑ I want to be interviewed if such a report is obtained.

H. I have read this Permit and know I may request a copy of it. I may revoke this Permit by writing to Lincoln Benefit Life Company. I also have received the Disclosures and Notices.

Declarations

A. I (each undersigned) declare that all answers written on this application are full and correct to the best of my knowledge and belief. Except in Maine, Missouri, New Jersey, Oregon, and South Carolina, Lincoln Benefit Life Company is not presumed to know any information not in this application.

B. Lincoln Benefit Life Company may add to or correct the application on an addendum page immediately following the application. Any changes are agreed to if I (we) accept the policy, but written agreement will be obtained from me for any change in insurance amount, plan, benefits, payment class or age at issue. (In West Virginia, Maryland, and Pennsylvania, written consent will be obtained for any changes.)

C. Insurance will start only as provided in the Receipt and Temporary Insurance Agreement issued in connection with this application. If no receipt is issued or if insurance under it has stopped and not started again, no insurance will start by reason of the application until the policy is delivered and the first premium paid in full. No insurance will start if at that time the health of all Proposed Insureds is not as described in the application.

D. I have read and understand this application, including the Disclosures and Notices, which I acknowledge receiving.

E. Only an officer of Lincoln Benefit Life Company may change this application or waive a right or requirement. No agent may do this.

ALL QUESTIONS WERE ASKED OF ME AND, IF APPLICABLE, THE ADDITIONAL/JOINT INSURED AND PARENTS OF ANY CHILDREN LISTED ON THIS APPLICATION. I (WE) HAVE READ ALL INFORMATION BEFORE SIGNING.

I declare that the answers written above are full and correct to the best of my knowledge and belief. I understand and agree that the statements above, along with the application, will be the basis for any insurance issued.

SUBSTITUTE FORM W-9 **Under penalties of perjury, I certify that:**

1. **The number on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and**
3. **I am a U.S. person (including a U.S. resident alien).**

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Sign Here

Signed at (City, State) Date (MM/DD/YYYY) Signature of Owner (and title, if a business or organization)

Signature of Primary Proposed Insured Signature of Additional/Joint Insured

Signature of Agent Signature of Parent/Legal Guardian (if any Insured is under Age 15)

Disclosures and Notices (Must be provided to the Proposed Insured.)

IMPORTANT INFORMATION REGARDING MEDICAL EXAMS

As part of the underwriting process we may ask for medical tests or exams to be completed at our expense. Common tests may include a paramedical exam, which will consist of questions about your medical history and measurements of your body including, but not limited to height, weight, blood pressure, and pulse. Blood and urine specimens are also generally collected. Undressing is not required for any of these tests.

In some instances, an EKG (Electrocardiogram) may be required. An EKG is a recording of the electrical impulses in the heart. You will be asked to lay down with your shirt unbuttoned so the EKG leads can be placed on your chest.

If you have any questions about the specific tests that will be required of you, please feel free to contact your agent.

NOTICE REGARDING THE MIB

Information regarding insurability will be treated as confidential. We or our reinsurer(s) may make a brief report to the Medical Information Bureau, Inc. (MIB). The MIB is a non-profit membership organization of life insurance companies. The MIB operates an information exchange on behalf of its members. If you apply to another MIB member for life or health insurance, or a claim for benefits is submitted to such a company, the MIB may supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Its telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

We or our reinsurer(s) may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

We will rely primarily on the information you give us. We may also get information from other sources, such as doctors, or other medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to gather information and send us an investigative consumer report as explained in the Notice Under the Federal Fair Credit Reporting Act below. You may ask to be interviewed as part of the preparation of any such report.

In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

You have the right to be told about and to see and copy items of personal information about you that appear in our files, including information contained in the investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to Underwriting Department, Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501.

NOTICE UNDER THE FAIR CREDIT REPORTING ACT

In compliance with the Federal Fair Credit Reporting Act, you are hereby notified that an investigative report may be made. This would be by personal interviews with neighbors, friends, associates, or other persons. This will concern the character, general reputation, personal characteristics, and mode of living (except as may be related to sexual orientation) of any person proposed for insurance. You may obtain additional information concerning the nature and scope of this investigation and a written summary of your rights under the Federal Fair Credit Reporting Act by contacting our Home Office. Our address is Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, Nebraska 68501. Upon your written request, you will be informed whether or not an investigation was made by us. If so, you will receive the name and address of the consumer reporting agency involved. You may receive and inspect a copy of the Investigative Consumer Report by contacting the consumer reporting agency.

IMPORTANT INFORMATION

For Applicants in Arkansas, Kentucky, Louisiana, Maine, New Mexico, Ohio, and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Applicants in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Applicants in District of Columbia, Tennessee, Washington and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

For Applicants in Florida: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

For Applicants in Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Applicants in New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Receipt and Temporary Insurance Agreement (Referred to as "Agreement")

Lincoln Benefit Life Company, P.O. Box 80469, Lincoln, NE 68501-0469

- **This Agreement must be given if payment is submitted with the application.**
- **Do not submit money or give this Agreement if the amount of insurance applied for on any one life exceeds $1,000,000.**
- **All checks must be made payable to the Lincoln Benefit Life Company. Do not make checks payable to the agent or leave the payee blank.**
- **Do not submit money or give receipt if any questions 5(a-f) in Section H are answered "yes" or not answered.**

$ _____ has been received from _____ (Payor) as a payment for the life insurance on _____ (Insured/Additional/Joint Insured) applied for on this date, except as limited in the Amount of Insurance section below.

NO INSURANCE WILL TAKE EFFECT EXCEPT AS DESCRIBED BELOW:

When Temporary Insurance Starts

If payment of at least one-twelfth of the annual premium for the policy applied for, including any riders and supplemental benefits, has been accepted by us and the application for life insurance has been completed on or before the date of this Agreement, temporary insurance under the Agreement will start on the later of: (1) the date of the Agreement, or (2) the date when all required medical exams have been completed and/or lab specimens (blood, urine, or oral fluid) provided.

When Temporary Insurance Will Stop

Temporary insurance under this Agreement will stop on the first of the dates below:

1. The date we write to the Owner that we have stopped considering the application, which is our absolute right.
2. The date we advise the Owner that a medical exam or lab specimen is required, in which event insurance will stop with respect only to the person(s) to whom such requirement(s) apply. Insurance under this Agreement will start again for such person when the last of such medical requirements is done. We have the absolute right to require such medical exams and lab specimens.
3. The date we agree to issue the coverage as applied for in the application. The insurance will then be provided by the policy.
4. The date we offer to issue insurance other than as applied for in the application. We may offer to issue insurance other than as applied for in the application on any person(s) proposed for this insurance.

We will refund all payments for which this Agreement was given if we stop considering the application.

Amount of Insurance

If temporary insurance under this Agreement is in effect, it will have the same benefits, provisions, and limitations and be for the same amount as the plan applied for. But we will provide no more than a combined total of $1,000,000 of temporary life insurance and accidental death benefit on any one life under this and any other Temporary Insurance Agreements, regardless of the insurance applied for under this application.

Conditions Under Which There is No Coverage

1. No insurance coverage starts under this Agreement, and we will only pay a refund of the payment made with the application if, in the past 10 years, anyone proposed for insurance has:
   a. been charged with a felony; or
   b. used or been arrested for possession, sale or delivery of illegal drugs; or
   c. sought or received treatment or advice for use of cocaine, heroin, narcotics, hallucinogens or other mind-altering substances not prescribed by a physician; or
   d. been diagnosed or treated by a physician for heart attack, coronary artery disease or stroke, or been told they had any of these disorders; or
   e. been treated for or diagnosed with cancer other than basal cell skin cancer; or
   f. been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or been told they have AIDS.
2. No insurance coverage starts under this Agreement if, in the answers in the application, there is any fraud or misrepresentation material to our acceptance of the risk. If there is fraud and/or material misrepresentation, we will only pay a refund of the payment made with this application.
3. No insurance coverage starts under this Agreement if a person proposed for this insurance dies by suicide while sane or self-destruction while insane. In this event, we will only pay a refund of the payment made for that person's insurance. Temporary Insurance will continue on all other Proposed Insureds whose coverage is not contingent on the insurance of the person who died.
4. No insurance coverage starts under this Agreement if no payment is received, if a check or draft given as a payment is not honored by the bank or, in the case of a credit card payment, the charge is refused by the credit card issuer.

No one can waive or change any of the terms of this Agreement.

_____ Agent Name

_____ Date (MM/DD/YYYY)

Premium Finance Supplement to Life Application

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

Lincoln Benefit Life Company
P. O. Box 80469, Lincoln, NE 68501-0469
Tel: 800-525-9287

Primary Proposed Insured | Date of Birth (MM/DD/YYYY)

Policy Owner (if other than Primary Proposed Insured) | Policy Number (if assigned)

This Supplement is required if Section I, Question 1, of the life application (Form LA2008 series) is answered "yes." It is not required if premiums are being loaned by an employer as part of a split-dollar financing arrangement. In the questions below, "you" refers to both the proposed insured(s) and the proposed policy owner(s) unless otherwise indicated. Where the answer requires explanation, please indicate the party(ies) to whom the explanation applies.

1. Name and address of the premium finance lender:

2. Marketing name of the premium finance program, if other than the lender's name:

3. Name of the organization or individual arranging the loan, if other than the lender:

	Yes	No
4. Do the terms of the loan require payment of at least the interest on an annual or more frequent basis? (If "no," when and how are interest and principal required to be paid?)	❑	❑
5. Do you intend to repay the loan from current income? (If "no," please describe the assets you intend to liquidate or other financial resources you intend to use to repay the loan.)	❑	❑
6. Were you given a copy of a loan term sheet that shows the interest rate, loan origination fees, maturity date, and prepayment penalties? (If "yes," please provide a copy.)	❑	❑
7. Is the life insurance policy the only collateral for the loan? (If "no," please describe the other assets you are pledging as collateral.)	❑	❑
8. Are you being loaned any additional amount beyond the amount required to pay the premiums for the proposed policy? (If "yes," please provide details.)	❑	❑
9. Have you (or a family member or other party of your choice) been offered any cash payment, free trip, or other inducements in exchange for purchasing the life insurance or taking out the loan? (If "yes," please give details.)	❑	❑

Continuation of Premium Finance Supplement to Life Application

	Yes	No
10. Do you anticipate satisfying all or part of the loan by transferring or selling the life insurance policy or any rights in the policy to the lender or any other party? (If "yes," give details.)	❑	❑
11. Within the last two years, have you (the proposed insured(s)) authorized a life expectancy assessment to be performed, or have you been told that a life expectancy assessment is required in connection with this policy or the premium finance loan? (If "yes," give details.)	❑	❑

I (each undersigned) declare that all answers written on this application supplement are full and correct to the best of my knowledge and belief. I understand and agree that this application supplement will be made a part of the application and of any policy issued as a result of the application.

Sign Here

Signed at (City, State)	Date (MM/DD/YYYY)
Signature of Primary Proposed Insured	Signature of Additional/Joint Insured
Signature of Owner (if other than Primary Proposed Insured)	Signature of Agent

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALSB-125531450*	*State:*	*Arkansas*
Filing Company:	*Lincoln Benefit Life Company*	*State Tracking Number:*	*39394*
Company Tracking Number:	*LA2008 SERIES*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LA2008 series*		
Project Name/Number:	*LA2008 series/LA2008 series*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 03/10/2008

Comments:

Attachment:

AR Compliance Certification.pdf

Review Status:

Satisfied -Name: Application 03/10/2008

Comments:

Please see Form Schedule for application forms being filed for approval.

Review Status:

Satisfied -Name: Readability Certification 06/24/2008

Comments:

Attachment:

Readability Certification CW.pdf

Review Status:

Satisfied -Name: Statement of Variability 06/24/2008

Comments:

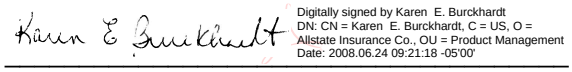
Attachment:

CW SOV.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

I hereby certify that to the best of my knowledge and belief this submission complies with Ark. Code Ann. 23-79-138, Regulation 49, and Regulation 19.



June 24, 2008
Date

Signature of Officer

Karen Burckhardt
Name

Assistant Vice President
Title and/or Business Affiliation

LINCOLN BENEFIT LIFE COMPANY
READABILITY CERTIFICATION

I hereby certify the accuracy of the Flesch reading ease test score for the following policy forms. These forms are at least ten (10) point type, two (2) point leaded.

TITLE	FORM NUMBER	FLESCH SCORE
Application for Life Insurance	LA2008	47
Temporary Insurance Agreement	LA2008TIA	51
Premium Finance Supplement to Life Application	LA2008PF	55

Karen E Burckhardt

Digitally signed by Karen E. Burckhardt
DN: CN = Karen E. Burckhardt, C = US, O = Allstate Insurance Co., OU = Product Management
Date: 2008.06.13 13:49:28 -05'00'

Karen Burckhardt, Assistant Vice President

June 13, 2008

Statement of Variability

The purpose of this document is to identify and explain the variable items in these forms. This information is organized by page number and lists those items that are variable and the reasoning for doing so. Any changes made will be for future use only and on a non-discriminatory basis.

Application Form LA2008 series

Page 1:

1. Company Address

a. Our company address and telephone number are variable so we can revise them when and if they are changed without re-filing this form with your Department.

Page 3:

2. Section E – Citizenship

a. This section is bracketed so that if the Federal laws governing these requirements are changed, we will have the flexibility to revise accordingly without filing with your Department.

3. Section F – The Policy

a. This section is bracketed so we may use this application with future products that may have more options than those listed.

Page 6:

4. Declarations

a. "Maine, Missouri, New Jersey, Oregon, and South Carolina" in Item A.

i. The states mentioned above are bracketed so that if additional states need to be added or existing states need to be deleted from this list, we will have the flexibility to revise it without filing with your Department.

b. "(In West Virginia, Maryland, and Pennsylvania,)" in Item B.

ii. The states mentioned above are bracketed so that if additional states need to be added or existing states need to be deleted from this list, we will have the flexibility to revise it without filing with your Department.

5. Substitute Form W-9

a. This section may be modified to include new information as required by state or federal requirements.

Page 7:

6. Notice Regarding the MIB

a. The address and telephone number for the MIB's information office are variable so we can revise them when and if they are changed without re-filing this form with your Department.

7. Insurance Information Practices

a. Our company address is variable so we can revise the address when and if it is changed without re-filing this form with your Department.

8. Notice Under the Fair Credit Reporting Act

a. Our company address is variable so we can revise the address when and if it is changed without re-filing this form with your Department.

9. Important Information

a. The information may be modified to include new information to comply with company, state or federal requirements.

Temporary Insurance Agreement Form LA2008TIA series

Page 1:

1. Company Address

a. Our company address is variable so we can revise the address when and if it is changed without re-filing this form with your Department.

2. "$1,000,000"

a. We bracket this information so that if this amount ever changes, we can revise it without having to file with your Department. We are filing this with a range of $1,000,000 to $2,500,000.

3. Amount of Insurance section – "$1,000,000"

a. We bracket this information so that if this amount ever changes, we can revise it without having to file with your Department. We are filing this with a range of $1,000,000 to $2,500,000.

Premium Finance Supplement Form LA2008PF series

Page 1:

1. Company Address

a. Our company address is variable so we can revise the address when and if it is changed without re-filing this form with your Department.